STATE MEDICAID P&T COMMITTEE MEETING

THURSDAY, May 31, 2007
7:00 a.m. to 8:30 a.m.
Cannon Health Building
Room 132

MINUTES

Committee Members Present:

Lowry Bushnell, M.D.
Karen Gunning, Pharm. D.
Jerome Wohleb, Pharm. D.
Thomas Miller, M.D.
Kort DeLost, R.Ph.
Raymond Ward, M.D.
Koby W. Taylor, Pharm. D.

Board Members Excused:

Dept. of Health/Div. of Health Care Financing Staff Present:

RaeDell Ashley
Jennifer Zeleny
Doug Springmeyer
Duane Parke
Lisa Hulbert
David Sundwall, M.D.

Other Individuals Present:

Ben Focht, Amylin
Barbara Boner, Novartis
Linda Craig, AztraZeneca
Tom Holt, Schering-Plough
Roy Linfield, Schering
David Steward, PhRMA
Linda Tyler, U of U
Spencer Guthrie, GSK
Trish McDaid-O'Neill, AstraZeneca
Rob Ward, Pfizer
Brett Brewer, EMD Serono
Robin Campbell, Merck/Schering-Plough
Reed Murdoch, Wyeth
Elizabeth Stoltz, J&J
Todd Burrows, Lilly
Candi Arce-Larreta, Pfizer
Mandy Hosford, AstraZeneca

Meeting conducted by: Duane Parke, P&T Committee Manager

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1. Housekeeping: Introduction of new members:

   - Dr. Thomas Miller is the Chief Medical Officer of the University of Utah Hospitals and Clinics, and has been with the University since 1988.
   - Koby Taylor is a pharmacist with Rite Aid in Bountiful, UT. He also teaches at the University of Utah.
   - The P&T Committee members were introduced to the new members.

2. Minutes for May 31, 2007 were reviewed, corrected, and approved.

3. New Business: Doug Springmeyer addressed the Committee. The Department posed several questions to Doug Springmeyer about the operation of the P&T Committee. It is his opinion

that Committee is subject to the Open and Public Meetings Act. A copy of the law was given to the P&T Committee members. The rule authorizing the formation of the P&T Committee is still pending and is not yet adopted. As such, the Committee has been advised to look at matters preliminarily, make planning steps to facilitate the prompt and appropriate adoption of a preferred drug list, but to defer final actions until such time as that rule becomes final.

On the first page of the of the statute that was handed out, under 52-4-103 definitions, subpart 4a defines what a meeting is. It also defines, under b, what a meeting is not, such as chance meetings, social meetings. Item 3, which says "the convening of a public body that has both legislative and executive responsibilities" probably pertains only to city and county councils that have that joint legislative and executive responsibilities. It is suggested to the P&T Committee that this does not apply to the Committee. This issue was raised to make it clear to the P&T Committee that this act only applies to them when they are together in a meeting. Members are not obligated to receive public comment outside of the meeting. As members agree to serve on the P&T Committee, they are not agreeing to make themselves available 24/7 to parties who may be interested in the issues that come before the committee. If members choose to receive communication, input, lobbying, etc. from parties that are interested in the actions pending before the Committee is at discretion of the members of the Committee. The Committee is encouraged to be open to public comment that is on the agenda, and is appropriately to be considered by the Committee. Committee members have no responsibility to receive these comments outside of the meetings.

Looking at 7a in the same section, "public body" means any administrative advisory committee of the State that is created by statute, rule, consists of two or more persons, and expends, disburses, or is supported in whole or in part by tax revenues, and is vested with the authority to make decisions regarding the public's business. Doug Springmeyer stated that it is his belief that the P&T Committee meets this definition, and that the P&T Committee is, therefore, subject to this act. The implication is that the P&T Committee is very restricted in how and when it can hold closed meetings and so-called executive sessions that restrict access by the public, allow members to have private discussions, and take votes in private. The statute does make allowances for private meetings, but they are largely inapplicable to the issues that are likely to come before the P&T Committee.

Turning to 52-4-202, a public body shall give no less than 24 hours public notice, including the meeting agenda, date, time, and place. That sets for the obligation that the Committee has to giving public notice. The notice, in specifying date, time, and place of the scheduled meetings must include an agenda. Item b requires reasonable specificity so that a person can be given advance notice with regard to the issues that are going to be considered. If there is a topic not listed on the agenda, which is raised for the Committee's decision, the Committee may discuss it, but not take any final action until it is on the agenda.

Statute 52-4-203 will apply to Duane, as staff to the Committee, and requires him to keep recordings and notes of the deliberations of the committee.

52-4-204 says that the Committee cannot hold a closed meeting unless 5-4-205 purposes are met. This is the key reason for Doug Springmeyer's addressing the Committee during this meeting. Under this statute, a closed meeting may only be held for the following reasons: discussion of the character, professional competence, or physical or mental health of an individual; strategy sessions to discuss collective bargaining (this is limited to labor negotiations); strategy sessions to discuss pending or reasonably imminent litigation; strategy

sessions to discuss the purchase, exchange, or lease of real property; and strategy sessions involving the sale of real property; discussion regarding the deployment of security personnel, devices or systems; investigative proceedings regarding allegations of criminal misconduct; and discussion by a county legislative body of commercial information as defined in Section 59-1-404. Unfortunately, items d and e only pertain to real property, and do not allow confidential pricing information from the drug companies to be shared with the P&T Committee, and item h only pertains to county legislative bodies.

The P&T Committee asked how they will be able to discuss or even know confidential pricing information, if all of the meetings are required to be public. Doug Springmeyer replied that this has been a key question for Duane and other employees of the Department. The Department had believed that confidential pricing information from the pharmaceutical companies would be provided to the members of the P&T Committee in a closed session, and that the Committee would be advising the Department on selecting appropriate pharmaceutical agents for the PDL based both on therapeutic value and cost. If the pharmaceutical companies provide confidential pricing information pursuant to the Governmental Records Act as a trade secret, which allows the Department personnel from further disclosure, and it is discussed by the P&T Committee, it will loose the protected status and become subject to public disclosure. This creates a dilemma for the Committee. The rule that proposes to empanel the P&T Committee discusses the recommendation of therapeutic issues. There is nothing in the rule that has the P&T Committee dealing with relative cost. For example, if the Committee concludes that all of the proton pump inhibitors are therapeutically equivalent, it would then be an easy matter for the Department staff to negotiate based on price. If the Committee concludes that one drug is clearly superior, it is possible that the Department would put that on the PDL because the drug is so much better than anything similar in that class. If there are two drugs in a class that the Committee determines are similar, the Department can negotiate on prices for those drugs and then ask the P&T Committee for recommendations based on one drug costing, for example, 5% less than another drug that was found to be similar, but not the same. Cost information can be considered, but it must be handled carefully if the drug companies are only willing to supply pricing information pursuant to the Trade Secret Exception under the Governmental Records Act. The Department has an obligation to protect the trade secret and not release it inappropriately.

The P&T Committee members stated that they were under the impression that they would be considering pricing information when they agreed to serve on the P&T Committee, since this how P&T Committees typically operate. If the P&T Committee cannot make a final decision based on cost, who will be making this decision? Doug Springmeyer stated that the DHCF Pharmacy Staff makes the final decision, according to the rule.

As the P&T Committee evaluates the relative therapeutic value of drugs and the P&T Committee takes votes on the relative therapeutic value of various drugs, it will absolutely need to be in an open meeting and the votes will be open to the public. The P&T Committee will be open to public scrutiny.

The P&T Committee members stated that Doug Springmeyer's legal advice will bifurcate the function of the P&T Committee by asking one body to look at relative therapeutic value and another body to consider cost. The P&T Committee asked if meetings that examine cost are required to be open to the public. Cost decisions will be made by Division staff, who are not subject to the Open and Public Meetings Act.

The P&T Committee members asked if they were able to view the pricing information for individual drugs privately, outside of the meeting. Doug Springmeyer stated that he believe that it would violate at least the spirit of the Open and Public Meetings Act, and that the public would have a legitimate concern that attempts were being made to circumvent the Act. P&T Committee members asked if they were able to at least discuss relative percentage differences in cost. The P&T Committee may discuss whatever they would like to discuss, that does not violate the trade secret.

In closing, Doug Springmeyer stated that it is the policy of the Department to be open to public comment, and that public comment was always welcome. P&T Committee members have been selected for their knowledge and scientific expertise. What weight and credibility they choose to give to information received from the public is why they serve on this committee. The P&T Committee asked if the information needed to be received in person or in writing. Doug Springmeyer stated that parties should be encouraged to get on the agenda or provide written information to an appropriate contact person. How the Committee handles public input will be decided once the rule is finalized and the P&T Committee is able to establish policies and procedures of its own.

The P&T Committee asked what body negotiates pricing for the Department. It will be the Division of Health Care Financing staff, Michael Hales, in consultation with Dr. Sundwall, and the leadership of the Medicaid program.

Dr. Sundwall addressed the Committee. Negotiating prices with pharmaceutical companies is a responsibility that the Division has done traditionally, has experience, with and has does well.

Dr. Sundwall thanked Doug Springmeyer for his presentation. Dr. Sundwall thanked the P&T Committee for their service, and stated that he has heard from key legislators who are very intent that the P&T Committee follow the Open and Public Meetings Act. The Committee should welcome comments from the public and from the pharmaceutical industry. He hopes that the P&T Committee members are not discouraged from serving, that they are somehow compromised from making specific decisions with cost data available. He encouraged P&T Committee members to provide their expertise in assisting the Department staff, who will be much better equipped to make decisions based on their input.

Barbara Boner asked to clarify if pharmaceutical industry representatives will be able to make spoken comments during Committee meetings, or if the Committee will still be able to take written comments only as originally decided. Duane Parke stated that the function of the Committee is still to look only at evidence-based medicine. If there is a study that has been published in a peer-reviewed journal that has not made it to the evidence-based centers, the P&T Committee could take it under consideration. Marketing materials, such as those for new drugs, should continue to go to the DUR Board. Karen Gunning stated that the Committee would need to figure out a way, through the policies and procedures of the P&T Committee after the rule is made, to balance the limited amount of time in a P&T Committee meeting and the potential large volumes of public comment.

Duane Parke addressed the Committee. He had given members a confidentiality statement that they needed to sign and return to the Department.

4. Top 15 Classes by Cost; by Volume: Karen Gunning addressed the Committee. In order for

the Committee to move forward over the next several months, the top 15 drug classes should be considered for discussion now, in order to allow the University of Utah Drug Information Service to prepare presentations for the Committee.

Duane Parke addressed the Committee. The Committee has been given a printout of therapeutic class codes, based on First Data Bank's schema, ranked by cost and by number of prescriptions. The Senate Bill that put the PDL into action has excluded atypical antipsychotics and traditional antipsychotics. Although they are the highest-cost item on the list, they cannot be considered. Aripiprazole is #6, and cannot be considered because it is an antipsychotic. All other classes can be considered. Class #7 is anti-haemophilic factors, and there is no opportunity for additional savings in that class, since Medicaid is already getting 340b pricing. The list provided to the Committee goes to 21 classes. The opportunity for savings really only takes in the first approximately 20 classes.

Karen Gunning asked the Committee for recommendations on classes that should be considered for a PDL. Dr. Ward had suggested a path for addressing the various groups on that list. Some of those groups cannot be addressed. Some of the groups are, perhaps, too large to talk about more than one group in one day. Some of the groups can easily be grouped together. For example, narcotics seem to be something that could be addressed in a timely manner. There are three groups of stimulants, three groups for asthma, two for diabetes, and two for sedatives. She asked for the Committees suggestions on how to handle these groups.

The Committee asked if there are copays on any of the categories. The maximum copay allowed by federal law is $3. Additionally, there are quantity limitations in place on narcotic pain medications such as Oxycontin, and certain other categories on drugs. The Committee asked if it was possible for the Department to restructure the copays based on preferred versus non-preferred drugs. It is possible to completely remove the copay from preferred drugs, but the copay cannot be higher than $3. It would also be possible to raise the dispensing fee for the pharmacy for preferred drugs.

The Committee asked if any of the drug categories would be non-payable by the Federal government. If the drug manufacturer pays a primary rebate to the Federal government, Medicaid has to cover the drug. Exceptions are made for certain categories, such as the drugs used for hair growing. Medicaid can restrict the drugs in any number of ways, but it must be reimbursable if the company pays a primary rebate. Certain excluded classes on Part D, such as OTC's, are reimbursable by Medicaid.

Duane Parke recommended that the P&T Committee address the SSRI's and antidepressants. Karen Gunning suggested a simpler topic to begin with. Other members of the Committee suggested that they consider antidepressants as a group in July, after votes are taken on PPI's and Statins. The motion to discuss antidepressants in July was passed.

For the following months, the Committee suggested antihypertensives. It was suggested that the class be initially discussed as a whole, to decide how to further subdivide the class. The motion to discuss antihypertensives was passed.

For the month after that, the Committee suggested stimulants. It was suggested that there were easier classes to deal with at first, that are more straightforward, and that could offer substantial savings. Some examples of those classes are asthma inhalers, insulin, diabetic

supplies. The Department also suggested that sedative-hypnotics may be an easy class to deal with, at first. Duane Parke suggested that sedative-hypnotics be considered first, and insulins next. The Committee agreed that these classes could be dealt with very quickly, and offer a substantial cost savings to the Department. A motion was made to rearrange the order of the classes under consideration.

The Committee asked Dr. Linda Tyler, of the University of Utah Drug Information Service, how long she would need to prepare presentations on the drug classes that the Committee would like to consider within the next 4-5 months. Some of the drug classes would require that the University review large volumes of data and take 3-4 months. Other classes may already be reviewed by Oregon Health Sciences Unviersity. This would greatly expedite the process. It would be important to know which drug classes have already been reviewed by Oregon, and which drug classes the University would need to review from scratch. The P&T Committee may want to choose 5 classes for the University to review.

The first two classes that are being reviewed by the P&T Committee have already been reviewed by Oregon. There may be some instances with the Oregon reviews, such as the review of the HMG Co-A Reductase Inhibitors, where some of the information is incomplete. For that class, Karen Gunning had requested two specific items for the Universisty that she thought would be helpful in conducting a complete review. The plan is, for the most part, to use the monographs that have been developed by Oregon to conduct reviews, since those monographs have been designed specifically for the types of reviews that the P&T Committee will be conducting. It is possible that some classes will not be available from Oregon. The Universisty can provide reviews for these classes. The Universisty will also be available to provide reviews to fill in any gaps in the data that is available from Oregon.

The Committee asked how an evidence-based review would handle a class like antihypertensives, where different agents can have different indications. Dr. Tyler stated that Oregon's review may have already considered all of these different facets of the information. If it hasn't, the Universisty could look at structuring the information to accommodate that. Oregon has reviewed some of the different antihypertensive classes, but they have not reviewed it as one entire class.

Oregon does a thorough review for each class. In each class, they set the criteria for the type of information will be used. They will default to randomized controlled trials, and default to the placebo controlled if those are not available. The decision will always be structured around differences in safety, efficacy, and differences in special populations. Different subsets may be considered in each class, but, in general, the three key clinical questions will be the same.

Duane Parke stated that there are about 45 states with preferred drug lists. The Department can bring in these lists for the P&T Committee so that the Committee can have some idea of what other states have done.

Karen Gunning suggested that the Committee choose 4-5 drug classes for review, the order of which will be dependant on the availability of information from either Oregon or the Universisty. It was suggested that the Committee consider antidepressants, antihypertensives, stimulants, and one other class. The Committee felt that it would be better to start with easier classes that could offer more savings up front for the Department, such

as blood sugar testing strips. Dr. Ward suggested antihypertensives, antidepressants, asthma medicines, stimulants, sedatives, diabetic, and antibiotics. Because some of these classes were so large, Karen Gunning suggested that it be left to the discretion of Duane Parke and Dr. Tyler to break down some of the classes further.

5. Statins: Dr. Linda Tyler addressed the Committee. Oregon has a panel of experts that develops key clinical questions around the review. Once the key clinical questions are developed, a thorough literature search of several databases is conducted. They then set up what types of studies they are going to look at. This particular monograph picked adult patients, trials of all of the Statins that are available on the market, one of three strategies - a fixed dose strategy, a single dose titration strategy, or a treat to a target LDL strategy. They excluded studies that did not provide any original data. They also excluded trials that were less than 4 weeks in duration. They then went through a data abstracting process, and did a validity assessment on the data.

   The first key clinical question was how do Statins compare in their ability to reduce LDL concentrations. In the summary of evidence, for patients who require a reduction of up to 35% to meet their goal, any of the Statins are effective. For patients who require 35-50% LDL reductions to meet their goal, atorvastatin 20mg or more, lovastatin 80mg, rosuvastatin 10mg or more, and simvastatin 20mg or more are more likely to meet that goal. Among the high-potency statins, atorvastatin 80mg daily or rosuvastatin 20mg or more reduced LDL's by 50% or more. Atorvastatin 80mg daily had a higher rate of adverse effects, in particular some of the GI side-effects than simvastatin 80mg daily. The adverse event rates in patients receiving rosuvastatin 40mg daily were similar to patients receiving atorvastatin 80mg daily.

   The University provided a table of equivalent doses. The University's assessment of equivalent doses between the Statins came to the same conclusions as Oregon's assessment. However, the University was asked to assess Vytorin, since Oregon did not include that in the assessment.

   The next key clinical question is how do Statins compare in their ability to increase HDL's. In the studies, the statins are provided in doses that reduce LDL's in equivalent amounts, then a similar increase in HDL's can be achieved. There is conflicting evidence about simvastatin and atorvastatin, with some studies showing no difference and some finding simvastatin superior. Some studies found increases in HDL with rosuvastatin compared to atorvastatin, while some studies showed no difference.

   The third key clinical question is how do statins compare in their ability to reduce the risk of non-fatal myocardial infarction, angina, cardiovascular mortality, all-cause mortality, stroke, and need for revascularization. In this particular class, there has been a lot of work around long-term outcomes. However, in the summary of the evidence, there is no information from any of the head-to-head trials in patients who have never had coronary heart disease or coronary heart disease endpoints. The data is primarily in patients with known coronary heart disease. In patients who had recent myocardial infarction, high dose atorvastatin 80mg reduced all cause mortality and CV events compared to pravastatin 40mg. For every 25 patients treated with atorvastatin 80mg instead of pravastatin 40mg, one coronary event was prevented. In another group of studies, patients who had a history of myocardial infarction and were treated with high dose atorvastation 80mg and simvastatin 20mg, patients did not differ in their outcomes on the primary endpoints.

The fourth key clinical question is if there are differences in the efficacy or safety of the statins for different demographic groups. There is good evidence from the randomized clinical trials that women and the elderly benefit from statins. The Oregon monographs will always separate these groups out - in some groups of drugs there is not sufficient data for women or the elderly in clinical trials. Data about safety and efficacy for African-Americans, Hispanics, and other ethnic groups is weaker, but there is no evidence that any one statin is safer in any of these groups.

Question number five is if there are any differences in the safety of the statins. There is insufficient evidence to determine which statins are safer in terms of muscle and liver toxicity. The University has provided supplemental material to address this question. The Oregon monograph, in wanting to be thorough and including only randomized controlled trials, excluded the very trials needed to look at adverse effects, especially adverse effects that are rare, such as rhabdomyelosis, liver toxicity, and renal toxicity. There is a whole host of other epidemiology trials that need to be looked at to get an idea where the data fall. The key adverse effects that should be looked at are comparisons of skeletal muscle toxicity, like myopathy or rhabdomyelosis. On one hand, there is no data that shows that one statin is safer in this regard than others. The risk seems to be similar with all available agents, except rosuvastatin. This was one of the key issues when rosuvastatin was being considered for the market. In the original clinical trials, many of the patients who had received 80mg developed rhabdomyelosis. This is why the 80mg dose is not approved in the United States. Putting that dose aside, it all seems to be similar. Whether or not this is a dose-related side effect is controversial. Many of the package inserts state that it is a dose-related side effect; however, few clinical trials that confirm that. The event is very rare, occurring only 0-0.2% of the time.

The P&T Committee asked Dr. Tyler if demographic differences were seen in the patients that did develop rhabdomyelosis. This is difficult to determine, since it is such a rare side effect. About 50% of the patients that did develop rhabdomyelosis where on other drugs that may cause a drug interaction that may cause rhabdomyelosis. Other than that, while there may be some risk factors for rhabdomyelosis, it is difficult to determine what those are because it is such a rare event. The strongest risk factor is that the patient is on other drugs that contribute to developing it.

The next event is the risk of hepatotoxicity. There are no trials that have evaluated this specifically in the epidemiology evidence. It appears that it is fairly similar. This is a fairly low event at a 0.5-2%. It also appears to be dose-related.

The last event is the issue related to renal side-effects. There have been no comparative trials, and evidence suggests that the risk is similar, except with rosuvastatin. This was a key issue in the approval process with rosuvastatin. It seems to have a little higher risk with respect to proteinuria and hematuria. The rate is very low, and appears to increase with the dose in about 10-40% of the studies. Whether or not this is a clinically relevant issue has not been answered by any of the available trials.

In summary, these drugs, when used in equipotent doses, appear to be similar. There are some nuances in terms of the side-effect information. All of them can be used safely, and patients need to be monitored for some of the adverse effects.

Karen Gunning asked if there were any Utah-specific questions that the Committee wanted

Dr. Tyler to address. One of the issues that had been raised at the DUR Board was the fairly high number of patients on Utah Medicaid that were on fairly low-potency statins. Medicaid had asked the Committee to look at high-potency statins. However, Oregon did not address the high-potency statins as a separate group. The Committee was asked if they wanted to address statins as a group, or only high-potency statins. The Committee asked if the cost data provided for the statins was grouped by high-potency statins, or if it reflected spending on the class as a whole. Duane Parke stated that Medicaid had joined the Sovereign States Drug Consortium (SSDC), which looked only at the high potency statins. The Committee members felt that statins were only one class. The low potency statins have generics available.

The P&T Committee members asked how the pricing contracts will work, and how Medicaid will go about obtaining contract prices once the Committee makes recommendations on the different agents and dosing. To minimize turnover, SSDC typically contracts with drug manufacturers for up to three years to lock in a secondary rebate. The SSDC meets yearly, to review contracts and any significant changes to the market. If an drug becomes available as a generic, that is a significant issues that needs to be looked at. In the case of statins, the state of Maine has included all of them on the PDL. All of the manufacturers offered a secondary rebate that enabled them to be covered. In the SSDC, manufacturers can bid to be single preferred agents, co-preferred agents, or to be included as steps within step therapy. Most states pick one to two preferred agents.

The P&T Committee members asked if it was possible for Medicaid to educate physicians about dosing guidelines based on the percent reduction needed for the patient to get to goal. Dr. Ward did not think that Medicaid had the ability to provide that type of education to physicians. Physicians are used to working with preferred and covered versus non-preferred and prior authorization required or writing "DAW-medically necessary". Karen Gunning pointed out that there is a disconnect between what physicians are actually prescribing and evidence. The use is in very low doses of atorvastatin, and the evidence suggests that patients need to have greater reductions. This suggests that patients are either very under treated, or need very little statin.

Karen Gunning stated that the Committee needs to look at this group and determine if all the agents are on an equal playing field in terms of efficacy. For up to 35% LDL reductions, it looks like they are. For the higher doses, it appears that there are 3-4 agents that are equivalent in terms of higher reduction. The next question becomes safety. The Committee was asked for input with regards to safety. The Committee felt that the issue of safety was most related to co-administration of other drugs.

Dr. Ward asked Medicaid to clarify the type of output was wanted from the Committee. One possible way to handle it would be to make one of four recommendations about a drug:

1. Preferred, with no copay.
2. Preferred.
3. Non-preferred.
4. These drugs appear to be of equal value; make a decision based on pricing.

The Committee felt that in the case of statins, it needed to be made clear that statins needed to be available at both lower potency and higher potency doses, so that physicians could choose a preferred agent based on the level of LDL reduction that was needed.

Duane Parke suggested that he bring a schema of relative costs to the next meeting, where

less expensive to more expensive drugs were indicated by one to four or five dollar signs. The copay reduction would need to be further considered by Medicaid, but the P&T Committee could make that suggestion.

The P&T Committee asked Dr. Tyler if there were any differences of compliance among the agents, and if any generics were going to be coming out in the next several years that the Committee needed to consider as a potential cost implication. The Committee also asked for compliance data among Medicaid clients. The Committee also wanted to know what drugs were commonly being prescribed in clinical practice, and choose an agent that was both cost-effective and caused the least disruption to clinical practice. Medicaid provided usage data for twelve months. Sometimes, clients will only be on Medicaid for a couple of months before they find a job and move to other insurance coverage, so the average number of months that a client receives a statin can be skewed pretty quickly. The number of units and the average cost per client is also provided. Medicaid can provide additional data, at the Committee's request.

Dr. Ward felt that there is not a significant difference among the statins as far as patient compliance. Patients, especially Medicaid patients, tend to take drugs that they can afford. Other insurance companies already drive prescribing habits with their policies, so the P&T Committee is not likely to make any recommendations that are out of line in what is already going on with other insurance companies. Even waiving the $3 copay is likely to make a difference for a Medicaid patient's compliance.

Dr. Tyler stated that the Oregon review does not include compliance data. One of the downsides of looking at a randomized controlled clinical trial is that compliance has been optimized. Because of this, randomized controlled clinical trials may or may not match what is seen in the general population. In several of the clinical trials, atorvastatin had slightly more discontinuation because of some of the side effects; most of these were GI side effects, particularly at the higher doses.

The P&T Committee asked how non-preferred prescriptions would be handled. The prescriber would either need to write "DAW - medically necessary" on the prescription and document medical necessity in the chart, or the pharmacist would have to call the prescriber and ask him or her to substitute the preferred agent. Pharmacists may not do therapeutic substitutions without consulting the prescriber, unless there is an agreement between the two parties for collaborative medication management. This type of agreement exists at the University of Utah and many hospitals, but is not common in the community. Medicaid also plans to make the preferred drug list available to prescribers at the point of care through Epocrates. Prescribers will be able to download Epocrates for their Palm, Blackberry, or other handheld device for free, and access Medicaid's PDL like they can access other insurance companies' formularies.

For the next meeting, Dr. Ward made a motion that the Committee recommend agents into one of four categories:

1. Preferred, with no copay.
2. Preferred.
3. Non-preferred.
4. Completely equal; Department may make a decision based on pricing.

These four broad categories could be amended based on the needs of a specific drug class. The Committee decided to further discuss this structure at the next meeting.

Next Meeting Set for Friday, July 20 2007.
Meeting Adjourned.